

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/14/2011	
NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/14/11</p> <p>Facility Number: 000306 Provider Number: 155694 AIM Number: 100273860</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Betz Nursing Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully</p>			K0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey review on or after October 14, 2011.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0014 SS=E	<p>sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 115 and had a census of 93 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/20/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed within exit access for 6 of 7 corridors in the facility. This deficient practice could affect all occupants except those of 200 hall.</p>			K0014	<p>K014It is the practice of this provider to provide flame spread rating of interior finish materials.What corrective Action will be accomplished for those residents found to have been affected by the deficient practice?The maintenance supervisor/designee has obtained the data sheets indicating the fire classification of flooring. He will keep the information in a binder or file folder. This will be</p>		10/14/2011

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	<p>Findings include:</p> <p>a. Based on observations with the Maintenance Supervisor on 09/14/11 during the tour from 12:40 p.m. to 2:08 p.m., carpet was installed on the nurses' desk at the west and central nurses' station. Also, carpet was installed on the wall below the reception window in the center hall.</p> <p>b. Based on observations with the Maintenance Supervisor on 09/14/11 from 2:47 p.m. to 2:49 p.m., laminate flooring material was installed on the bottom portion of the corridor wall on 400, 500, 600 and 700 halls. Based on an interview with the Maintenance Supervisor at the time of observations, this was done recently as part of the renovation process. Based on an interview with the Maintenance Supervisor at the time of observations, no documentation was available to demonstrate the carpet and the laminate flooring material provides a flame spread rating of Class A or Class B.</p> <p>3.1-19(b)</p>				<p>accessible to any person who should have need to see such information in order to ensure safety of those in the building. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. The maintenance supervisor/designee has this information in his file drawers. He will be sure that the management team is aware of its whereabouts and make it easily accessible. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur? All new materials will be logged and the flame spread rating sheets filed in the maintenance director's binder or folder. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Life Safety Review CQI tool will be utilized. The Executive Director is responsible to ensure compliance. This will be submitted for review at the monthly safety meeting if threshold not achieved.</p>		

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K0017 SS=E	<p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 lounges on 700 hall was separated from the corridors by a partition capable of resisting the passage of smoke, or met an Exception. LSC 19–3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection</p>			K0017	<p>It is the practice of this provider to ensure that each space is protected by an electrically supervised automatic smoke detection system. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The maintenance director worked with the construction manager to get the smoke detector installed by SafeCare on 9/20. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Four(4) residents were potentially affected. The maintenance director will conduct daily inspections during the remaining construction period to</p>		09/20/2011

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	<p>system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect four residents on the 700 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 09/14/11 at 3:07 p.m., the newly construction 700 hall lounge was separated from the corridor by a half corridor wall. Furthermore, Exception # 6, requirement (a) of the LSC Section 19–3.6.1 was not met because the 700 hall lounge was not protected by an electrically supervised automatic smoke detection system. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1–19(b)</p>				<p>insure that any potential area of smoke passage is electronically monitored by the automatic smoke detection system. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance director will make a written report to Executive Director and Construction Manager of his daily findings of any areas that need to be electronically monitored by the automatic smoke detection system. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The written report will be discussed in morning meeting and in monthly safety committee for the duration of the construction project.</p>		

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K0018 SS=E	<p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 8 resident room corridor doors on 200 hall closed and latched into the door frame. This deficient practice could affect any of the 13 residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/14/11 at 1:08 p.m., the corridor door to resident room 207 failed to latch into the door frame. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>			K0018	<p>It is the practice of this provider to ensure there is no impediment to the closing of doors that resist the passage of smoke. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The door on room 207 was repaired by maintenance on the day of survey. The knob was adjusted and the door now latches into the frame. The glove box holding open the door of the central supply room was removed on day of survey and will no longer be propped open. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken? 13 residents have the potential to be affected by the alleged deficient practice. Repair service was performed/completed by maintenance staff immediately upon finding it was needed. What</p>		09/14/2011

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	<p>2. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 1 of 3 service hall doors protecting corridor openings. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/14/11 at 1:50 p.m., the corridor door to the central supply office was propped open with a box of gloves. Based on an interview with the Maintenance Supervisor at the time of observation, he thought it could be propped opened as long as there were office personnel in the room.</p> <p>3.1-19(b)</p>				<p>measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Monthly CQI tool will be implemented times 3 months and then quarterly thereafter to check that resident room doors latch into frame and that no doors have anything impeding their closure in the event of smoke. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance director/designee will review environmental safety-resident area CQI tool at the monthly safety committee meeting. The Executive Director is responsible to ensure compliance.</p>		

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K0025 SS=E	<p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 3 of 7 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining</p>			K0025	<p>It is the practice of this provider to ensure that penetrations of the smoke barriers are filled with material capable of maintaining the smoke resistance of the smoke barrier. What corrective action will be accomplished for those residents found to be affected by the deficient practice? The drywall in the attic of the 700 smoke barrier was replaced/repared by maintenance on 9-20-11. Expandable foam was removed in the smoke barrier between central and east hall. It was resealed with fire retardant caulk on 9-22-11. The smoke barrier by the activity office has had the 3 areas sealed with fire retardant caulk on 9-22-11. How will you identify other residents having the potential to be affected</p>		09/22/2011

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	<p>the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect six of eight smoke compartments.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Supervisor on 09/14/11 from 3:20 p.m. to 3:35 p.m., the following smoke barrier walls had unsealed penetrations or penetrations sealed with an unrated material:</p> <p>a) in the attic of the 700 smoke barrier wall there was a section of drywall removed measuring three feet tall by one foot wide</p> <p>b) expandable foam which was not fire rated was used to seal at least three penetrations in the smoke barrier wall between the central and east hall</p> <p>c) in the attic of the smoke barrier wall by the Activities office a three inch sleeve, a two inch sleeve and a one half inch penetration had not been sealed.</p> <p>This was acknowledged by the Maintenance Supervisor at the time of observations.</p>				<p>by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Repairs were performed/completed by maintenance upon finding. All compartments were inspected upon this survey and no other alleged deficient practice found needing action. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice will not recur? During the remainder of construction and as appropriate thereafter, Maintenance Supervisor/designee will follow behind any work on or near smoke barriers to assure there is no penetration that will provide a way for smoke to travel thru. A written report will be provided to the Executive Director of any findings. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance director/designee will review findings and corrective actions at monthly Safety Committee meeting.</p>		

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K0029 SS=E	<p>3.1-19(b)</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 water heater rooms, a hazardous area, on 200 hall was provided with a self closing device. This deficient practice could affect any resident near the 200 hall water heater room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/14/11 at 1:02 p.m., the corridor door to the 200 hall water heater room was equipped with a</p>			K0029	<p>It is the practice of this provider to have self closing doors and/or doors that latch into the door frame on corridor doors of hazardous areas(water heater rooms and soiled utility rooms).What corrective action will be accomplished for those residents found to have been affected by the deficient practice?Maintenance supervisor/designee replaced the self closing device on the 200 hall water heater room. Additionally, latching door handles were installed on the soiled utility room doors in the 400, 600, and 700 hallways.How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?57</p>		09/23/2011

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	<p>self closing device but when opened the device had a feature that would hold the door open. This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 3 of 6 shower rooms used for storage of soiled linen, therefore creating a hazardous area, were provided with doors that would self close and latch into the frame. This deficient practice could affect any of the 44 residents on the 400, 600 and 700 halls.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/14/11 from 2:31 p.m. to 3:05 p.m., soiled linen barrels were stored in the 400, 600 and 700 shower rooms. These shower rooms lacked latching hardware and did not latch into the door frame. Based on an interview with the Maintenance Supervisor at the</p>				<p>residents had the potential to be effected by the alleged deficient practice. Maintenance supervisor/designee has completed the change of the defective hardware. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur? CQI tool for environmental safety will be implemented. Results will be monitored by environmental services. How will the corrective action be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will repair any negative results found on CQI tool and review the results at the monthly Safety committee meeting.</p>		

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K0038 SS=E	<p>time of observations, soiled linen is stored in these barrels until they are taken by the laundry staff to the laundry room.</p> <p>3.1-19(b)</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 9 exit discharge paths was readily accessible at all times. This deficient practice could affect any residents evacuated through the 200 hall exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/14/11 at 1:10 p.m., the 200 hall had two doors less than foot feet apart in the exit path. When the first door was opened into a small vestibule it hit the second door and could not be opened completely. The second door had to be opened in order to open the first door completely. This was acknowledged by the Maintenance</p>		K0038	<p>It is the practice of this provider to insure that all exits are readily available at all times. What corrective action will be accomplished for those residents found to have been effected by the deficient practice? Maintenance supervisor/designee will replace the door handle on the exterior door thus allowing the interior door to open completely for evacuation purposes. Temporary ramps will be put into place at the 300, 500, and 700, hall exits until the black top is installed. Signs were ordered 9-30-11, to notify all that the magnetic lock would release when the crash bar was pressed for 15 seconds. How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken? There were 73 residents potentially effected by this alleged deficient practice. By 10-14-11, Maintenance supervisor/designee will replace the door handle on</p>		10/14/2011	

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	<p>Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 9 exit discharge paths were readily accessible at all times. LSC Section 4.6.10.1 says portions of buildings shall be permitted to be occupied during construction and repairs only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place. This deficient practice affects any of the 34 residents on the 300, 500 and 700 halls in the event of an evacuation.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 09/14/11 from 12:48 p.m. to 3:12 p.m., the blacktop road has been removed from the 300, 500 and</p>				<p>the exterior door thus allowing the interior door to open completely for evacuation purposes. He will place temporary ramps wide enough to roll a bed over, providing egress from the building for the four inch drop created by preparing for the new blacktop of the drives. He will install the signs notifying how to operate the door in case of emergency evacuation. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur? Exits will be checked by maintenance supervisor/designee every 6 months to insure that all exit doors can be opened to their maximum potential and that there is less than a four inch drop from concrete to blacktop drive. It will be verified that there is nothing impeding the full operation of the exits for evacuation purposes. At that time, it will also be verified that the sign with operation directions for the 600 hall door is still in place and legible. How will the corrective action be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will complete a Life Safety CQI tool bi-annually in October and April. This will be reported in the monthly CQI meeting of those months. The Executive Director will be responsible for to insure compliance.</p>		

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	<p>700 hall exit egress path in preparation for a new blacktop road. The removal of the blacktop created a four inch drop off at each of these exits. Measurements were provided by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed-egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks requires all approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: On the door adjacent to the release device,</p>						

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	<p>there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1 / 8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect any of the ten residents on the 600 hall evaluated through the 600 hall exit in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/14/11 at 2:55 p.m., the 600 hall exit door from the facility was provided with a delayed egress magnetic lock that would open when the crash bar was pressed for fifteen seconds. The door was not provided with the required sign. This was acknowledged by the Maintenance Supervisor at the time observation.</p> <p>3.1-19(b)</p>						

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K0048 SS=F	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to provide a complete written fire plan that included the use of kitchen fire extinguishers for the protection of 93 of 93 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ul style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency when the written fire plan should be immediately available.</p> <p>Findings include:</p>			K0048	<p>It is the practice of this provider to provide a complete written fire plan to be immediately available in the event of an emergency. What corrective action will be accomplished for those residents found to have been effected by the deficient practice? A complete, facility specific fire safety plan, including the use of kitchen fire extinguishers, is now written and immediately available. How will you identify other residents having potential to be effected by the same deficient practice and what corrective action will be taken? All residents have the potential to be effected by the alleged deficient practice. The entire disaster action plan was revised and has all current information including the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur? Inservices will be conducted in October and November regarding the new disaster policy and the locations of those manuals in the building. Additionally, the new policy will be reviewed at the monthly CQI</p>		10/14/2011

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	<p>Based on a record review with the Maintenance Supervisor on 09/14/11 from 11:45 a.m. to 12:10 p.m., the policy and procedure for the written fire plan was found within three separate written manuals. The Maintenance Supervisor made numerous trips to the administrative offices searching for the required information. Portions of the written fire plan were found in the following documentation:</p> <p>a) the Betz Disaster Plan Policy & Procedure Manual Revised 03/09</p> <p>b) the ASC (American Senior Communities) Safety Manual affective date 01/01/04. Revision date 01/01/08</p> <p>c) the Disaster Action Plan received from ASC two weeks ago. This Plan was the corporate policy that required information specific to the facility. That information was not included.</p> <p>Additionally, none the these manuals addressed the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system.</p> <p>Based on an interview with the Maintenance Supervisor, ASC</p>				<p>meeting as well as the monthly safety meeting. How will the corrective action be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Executive Director will be responsible to monitor the plan monthly and make changes as appropriate.</p>		

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K0052 SS=E	<p>purchased the facility one year ago.</p> <p>3.1-19(b)</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 manual pull stations on the 500 hall were maintained to assure reliability. NFPA 72, 7-4.1 requires fire alarm system equipment be periodically maintained in accordance with manufacturer's instructions. This deficient practice could affect any of the 14 residents on the 500 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during fire alarm system testing on 09/14/11</p>			K0052	<p>It is the practice of this provider to ensure a fire alarm system required for life safety is installed, tested, and maintained. The system has an approved maintenance and testing program complying with the applicable requirements. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Repair service was performed/completed by SafeCare and determined cause of trouble was that the manual pull stations had not been wired in when the panel was moved for renovation. Fire watch was implemented until Safecare completed repair, completed testing on the pull stations, and ensured proper functioning. How will you identify other residents</p>		09/14/2011

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	at 3:50 p.m., none of the three manual pull stations located on the 500 hall actuated the fire alarm system during the fire alarm test. Based on an interview with the Maintenance Supervisor at the time of observation, he was not aware of this problem and stated the main fire alarm panel was recently moved to a different location. 3.1-19(b)				having the potential to be affected by the same deficient practice and what corrective action will be taken? Fourteen (14) residents had the potential to be affected by the alleged deficient practice. Repair service was performed/completed by SafeCare and determined cause of trouble was that the manual pull stations had not been wired in when the panel was moved for renovation. Fire watch was implemented until Safecare completed repair, completed testing on the pull stations, and ensured proper functioning. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Fire drills will be conducted, by the Maintenance Supervisor or designee, monthly using the effected pull stations to insure they are working properly. Any mal-function will be reported to Executive Director and SafeCare immediately. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance Supervisor/designee will review Fire drill reports and Life Safety CQI tool at the monthly safety committee meeting. The Executive Director is responsible to ensure compliance.		

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K0056 SS=E	<p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 4 building overhangs in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect any resident evacuated through the 300 hall in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the</p>			K0056	<p>It is the practice of this provider to insure that there is an automatic sprinkler system that provides complete coverage for all portions of the building. What corrective action will be accomplished for those residents found to have been effected by the deficient practice? PIPE, Inc has installed a sprinkler head under the overhang on the 300 hall exit and in the front office area. How will you identify other residents having potential to be effected by the same deficient practice and what corrective action will be taken? 10 residents had the potential to be effected by the alleged deficient practice. PIPE, Inc has installed a sprinkler head under the overhang on the 300 hall exit and in the front office area. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur? Inspections will be conducted and compliance will be</p>		10/14/2011

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	<p>Maintenance Supervisor on 09/14/11 at 12:48 p.m., there was a combustible overhang measuring five feet and five inches at the 300 hall exit which was not protected with sprinklers. Measurements were provided by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the sprinkler system provided complete coverage for 1 of 1 front office areas in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on an observations with the Maintenance Supervisor on 09/14/11 at 1:20 p.m., an area which was about 36 square feet in size located between the</p>				<p>supervised as required. Maintenance director/designee will monitor results and timeliness. How will the corrective action be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance director/designee will monitor the results and timeliness of the PIPE, Inc. inspections. Results will be reviewed and monitored with the Executive Director for compliance.</p>		

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K0062 SS=D	<p>reception office and the inservice coordinator's office lacked sprinkler coverage due to the placement of two sprinkler heads on the other side of a bulkhead which defined one side of the area. The spray pattern for these two sprinklers was blocked by the bulkhead. The other three sides of the area were defined by the walls of the offices and the glass door leading to the corridor. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>						
	<p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained in proper working order. This deficient practice</p>			K0062	<p>It is the practice of this provider to insure that automatic sprinkler system is continuously maintained in a reliable operating condition. What corrective action will be accomplished for those residents found to have been</p>		10/14/2011

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K0068 SS=D	<p>could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 09/14/11 at 4:35 p.m., the sprinkler inspection report dated 07/08/11 from P.I.P.E. titled "Report of Inspection" stated "Clapper gasket leak threw alarm line. To be serviced." Based on an interview with the Maintenance Supervisor at the time of record review, the Clapper gasket has not been serviced.</p> <p>3.1-19(b)</p>				<p>effected by the deficient practice?PIPE, Inc. has completed the service on the clapper gasket leak.How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?All residents have the potential to be effected by the alleged deficient practice. PIPE, Inc. has completed the service on the clapper gasket leak.What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur?Sprinkler system inspections will be conducted as required and according to the implemented schedule. Maintenance supervisor/designee will monitor results and timeliness.How will the corrective action be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place?Maintenance supervisor/designee will complete a Life Safety CQI tool. Results will be reviewed by the CQI committee and the safety committee, with action plans created as needed</p>		
	<p>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen offices was provided with intake combustion</p>			K0068	<p>It is the practice of this provider to have ventilation air taken from the outside for gas fueled water heater.What corrective action was accomplished for those</p>		09/14/2011

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	<p>air from the outside for any room containing fuel-fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon dioxide which could cause physical problems for the staff in the kitchen office.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/14/11 at 1:30 p.m., the kitchen office had a gas fueled water heater with a fresh air vent that had been capped off. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>				<p>residents found to have been effected by the deficient practice?The fresh air vent was uncapped immediately by the maintenance supervisor when found and in the presence of the surveyors. How will you identify other residents having the potential to be effected by the same deficient paracticer and what corrective action will be taken?No residents had the potential to be affected by the alleged deficient practice as this was in a kitchen office area. The fresh air vent was uncapped immediately by the maintenance supervisor when found and in the presence of the surveyors. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur?Certified Dietary manager and maintenance supervisor/designee will check the vent as part of their monthly walk thru to insure that fresh outside air is being provided to for the intake of the gas water heater.How will the corrective action be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place?Maintenance supervisor/designee will complete a Life Safety CQI tool. Results will be reviewed by the CQI committee and the Safety committee if an action plan is necessary.</p>		

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K0069 SS=E	<p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining</p>			K0069	<p>It is the practice of this provider to insure that there is a placard indicating that the K Class extinguisher is to be used as supplemental protection to the automatic fire suppression system. What corrective action will be accomplished for those residents found to have been effected by the deficient practice? A placard has been mounted next to the K class portable extinguisher indicating that it is to be used as supplemental protection to the automatic fire suppression system. How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken? Any residents using the main dining room adjacent to the kitchen could be effected by the alleged deficient practice. A placard has been mounted next to the K class portable extinguisher indicating that it is to be used as supplemental protection to the automatic fire suppression system. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur? Certified Dietary manager and maintenance supervisor/designee will check the placard as part of their monthly walk thru to insure that it is still in place as instruction for</p>		10/14/2011

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	room, located adjacent to the kitchen. Findings include: Based on observation with the Maintenance Supervisor on 09/14/11 at 1:35 p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Supervisor at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system. 3.1-19(b)				employees. All dietary staff will be inserviced about the K class extinguisher and its use. How will the corrective action be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Maintenance supervisor/designee will complete a Life Safety CQI tool. Results will be reviewed by the CQI committee and the Safety committee if an action plan is necessary		

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K0074 SS=C	<p>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>1. Based on observation and interview, the facility failed to ensure window curtains in 49 of 69 resident rooms, 1 of 1 lounges on 100 hall and 1 of 1 Restorative rooms were flame retardant. This deficient practice could affect any number of residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 09/14/11 from 12:35 p.m. to 2:10 p.m., the window curtains installed in forty nine resident rooms, the 100 hall lounge and the Restorative room lacked attached documentation</p>			K0074	<p>It is the practice of this provider to provide the flame retardant ratings of window curtains. It is also the practice to have 1/2 inch diagonal mesh cubicle curtains in the shower rooms.What corrective action will be accomplished for those residents found to have been effected by the deficient practice?Fire rating paperwork was found by the maintenance supervisor the next day. The one cubicle curtain was replaced that day as well with one that met the standard.How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken?All residents have the potential to be effected by the alleged deficient practice. Fire rating paperwork was found by the maintenance supervisor the</p>		09/15/2011

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	<p>confirming they were inherently flame retardant. Based on interview with the Maintenance Supervisor at 12:35 p.m., there was no documentation regarding flame retardancy for these window curtains available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure sprinklers in areas where cubicle curtains were installed in 1 of 6 shower rooms was in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Due to the lack of cubicle curtain and sprinkler location coordination which may obstruct the sprinkler spray onto the fire or may shield the heat from the sprinkler, this deficient practice could affect any resident in the 400 hall shower room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/14/11 at 2:30 p.m., the 400 hall shower room had a privacy</p>				<p>next day. The one cubicle curtain was replaced that day as well with one that met the standard. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur? All new materials will be logged and the flame spread rating sheets filed with the maintenance directors binder or folder. Current flame rates will be kept in a folder by the maintenance supervisor/designee. Management team will be inserviced on where these items are found and to make sure that cubicle curtains have the 1/2 inch diagonal mesh at the top during their customer care or weekend manager rounds. How will the corrective action be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Life Safety CQI tool will be utilized and reviewed by the maintenance supervisor/designee. Results will be reviewed at the monthly safety meeting if indicated.</p>		

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K0143 SS=E	<p>curtain that lacked 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 in. below the sprinkler deflector. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was separated from any portion of a facility wherein residents are housed, examined, or treated by separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect</p>			K0143	<p>It is the practice of this provider to insure that a one hour fire resistive door be on the oxygen transferring room. What corrective action will be accomplished for those residents found to have been effected by the deficient practice? A new door was ordered 9-29-11. It is to arrive by 10-7-11 and will be installed within the next 2 business days thereafter. How will you identify other residents having the</p>		10/14/2011

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K0147 SS=F	any resident near the oxygen room. Findings include: Based on an observation with the Maintenance Supervisor on 09/14/11 at 2:35 p.m., the door to the oxygen transferring room was a twenty minute fire rated door. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)			K0147	potential to be effected by the same deficient practice and what corrective action will be taken?The alledged deficient practice could effect any resident that was near the oxygen room. A new door was ordered 9-29-11. It is to arrive by 10-7-11 and will be installed within the next 2 business days thereafter.What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur?The regulations will be monitored. The Maintenance supervisor/designee will make the internal changes if NFPA 99 requires a higher fire resistive rating on oxygen transferring rooms.How will the corrective actions be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The Executive Director is responsible to ensure compliance by monitoring regulatory changes communicated by Life Safety consultant.		09/15/2011
	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords such as an extension cord were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to				It is the practice of this provider to insure that electrical wiring and equipment is in accordance with standards.What corrective Action was accomplished for those residents found to have been effected by the deficient practice?Extension cord for the emergency generator was		

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	<p>comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all occupants should a problem arise at the emergency generator.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 09/14/11 between 1:45 p.m. and 1:55 p.m., extension cords were noted in the following locations:</p> <p>a) a regular light weight extension cord was plugged in and providing power to a multiplug adapter which was supplying power to the coolant heater and the blocker heater of the emergency generator</p> <p>b) a regular light weight extension cord was providing power to a coffee pot in the Activities office.</p> <p>This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1-19(b)</p>				<p>replaced by a new outlet installation. The extension cord on the coffee pot in the temporary activity office was removed. The GFCI receptacle in the 200 hall clean utility has been rewired and is working properly. How will you identify other residents having the potential to be effected by the same deficient practice and what corrective action will be taken? None of these findings were in areas that would have directly effected residents. Extension cord for the emergency generator was replaced by a new outlet installation. The extension cord on the coffee pot in the temporary activity office was removed. The GFCI receptacle in the 200 hall clean utility has been rewired and is working properly. What measures will be put into place or what systemic changes will you make to insure that the deficient practice does not recur? Extension cords (flexible cord and lightweight extension cables) are not to be used. How will the corrective actions be monitored to insure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Life Safety CQI tools will be completed by the maintenance supervisor/designee. Data collected will be submitted to the CQI committee for review and an action plan developed if threshold is not met. The Executive Director is responsible to ensure</p>		

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	<p>2. Based on observation and interview, the facility failed to ensure 1 of 1 wet locations in the 200 hall clean utility room was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as areas subjected to wet conditions. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any staff using the sink in the 200 hall clean utility room in the event of an electrical short.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 09/14/11 at 1:40 p.m., the 200</p>				compliance.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2011

FORM APPROVED

OMB NO. 0938-0391

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	hall clean utility room had an electrical GFCI receptacle on the wall within three feet of a hand sink. When the test button on the GFCI receptacle was pressed, power was interrupted. But when tested with a GFCI testing device and the button was testing device was pressed, power was not interrupted. Also the indicator lights on the GFCI testing device indicated the GFCI receptacle was not wired correctly. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)						